Public Employees Benefits Board (PEBB)

2003 Retiree Medical and Dental Coverage

A

- List all family members you wish to enroll on this form.
- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- Dependents must be enrolled in the same plans as the retiree, except as specified for Medicare Supplement Plans E and J.

Retirement system name	**Retirement date** (mm/dd/yyyy)
PERS 1	

For K-12 school district retirees only:

When does your current school district medical/dental coverage end? (mm/dd/yyyy)	School district

SECTION 1: Retiree Information

Social security number	Sex ☐M ☐F	Last name	First name	Middle initial

Address

City	State	ZIP Code	County of residence

Date of birth (mm/dd/yyyy)	Work phone number (including area code)	Home phone number (including area code)

The medical plans marked with an asterisk (*) in Section 4 assign a physician or clinic code to their providers and require you to choose a primary care provider. **Contact your plan or go to the Provider Directory on our Web site for code.** ➧ Physician or clinic code

Are you or your spouse or same-sex domestic partner enrolled in both Parts A and B of Medicare?

Retiree ☐ Yes ☐ No

Spouse or same-sex domestic partner ☐ Yes ☐ No

Are you or your spouse or same-sex domestic partner on Medicare disability?

Retiree ☐ Yes ☐ No

Spouse or same-sex domestic partner ☐ Yes ☐ No

Note: *If you or your dependents are Medicare eligible, you must be enrolled in Medicare Parts A and B. If you haven't sent in a copy of your Medicare card(s), please send a copy of it along with this form.*

SECTION 2: Family Member Information

*List **only** family members you wish to cover; family members **cannot** be enrolled in any other PEBB coverage.*

Relationship to retiree

If enrolling a spouse/partner, please attach a completed *Declaration of Marriage/Same-Sex Domestic Partnership* form.

☐ **Spouse:** date of marriage _____

☐ **Same-sex domestic partner:** date criteria met _____

Social security number	Sex ☐M ☐F	Physician or clinic code (contact plan for code)

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Other Family Members (such as child, grandchild, etc.) ***Use additional forms for more members***

A **Relationship to retiree**

☐ Disabled? ☐ Student? *(Check only if age 20 or older)*

Sex ☐M ☐F

Social security number	Physician or clinic code (contact your plan for code)

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Address (if different from retiree)	City	State	ZIP Code

B **Relationship to retiree**

☐ Disabled? ☐ Student? *(Check only if age 20 or older)*

Sex ☐M ☐F

Social security number	Physician or clinic code (contact your plan for code)

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Address (if different from retiree)	City	State	ZIP Code

SECTION 3: Additions or Changes
(Check all that apply.)

Retiree changed: ☐ Name ☐ Address ☐ Medical plan ☐ Dental plan

Change in family status:

☐ **Adding a spouse or same-sex domestic partner.**
You **must** complete a Declaration, available from the Health Care Authority or online at www.pebb.hca.wa.gov

☐ **Adding family member A**

☐ **Adding family member B**

SECTION 4: Medical Plan Selection
(Check only one.)

☐ Group Health Cooperative of Puget Sound
☐ Group Health Options, Inc.
☐ Kaiser Foundation Health Plan of the Northwest
☐ PacifiCare of Washington, Inc.*
☐ Premera Blue Cross
☐ RegenceCare*
☐ Uniform Medical Plan
☐ Medicare Supplement Plan E, administered by Premera Blue Cross
☐ Medicare Supplement Plan J, administered by Premera Blue Cross

** These plans require the physician or clinic code of your selected primary care provider. Contact plan for code.*

SECTION 5: Dental Plan Selection
(Check only one.)

Preferred Provider Organization
(may receive services *from any provider*):
☐ Uniform Dental Plan (Group #3000)

Managed Care Plans
☐ DeltaCare (Group #3100)
Dentist name_____
(must receive services from *DeltaCare provider*)
☐ Regence BlueShield Columbia Dental Plan
Clinic location_____
(must receive services from *Columbia Dental Group provider*)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

SECTION 7: Life Insurance Enrollment Information

Retiree Term Life Insurance is **only available** to those who received PEBB coverage as an active employee. Application for Retiree Term Life Insurance must be made at the time of retirement.

I hereby elect to enroll in the PEBB Retiree Term Life Insurance Plan. ☐ **Yes** ☐ **No**

Disabled retirees who qualify for the waiver of premium benefit under the PEBB employee life insurance plan are not eligible for this Retiree Term Life Insurance Plan.

Age at Time of Death	Amount of Insurance in Force at Time of Death
Under 65	$3,000
65 through 69	$2,100
70 and over	$1,800

Beneficiary _____

Beneficiary's SSN_____ Relationship to retiree_____

Address_____

_____

SECTION 6: Waive or Terminate Coverage

Waiving medical coverage:

☐ **Self** (includes all family members)
I understand that proof of continuous, comprehensive, employer-provided medical coverage will be required to re-enroll in a PEBB medical plan. Application for reenrollment must be made within 60 days of the date I lose other coverage.

☐ **Spouse or same-sex domestic partner**

☐ **Other family member(s)** ☐ A ☐ B
I understand that proof of continuous, comprehensive medical coverage will be required to reenroll family members in a PEBB plan outside of an open enrollment period. If I die, my eligible dependent(s) must enroll in or waive PEBB coverage (due to enrollment in comprehensive employer-provided medical coverage) within 60 days of my death.

Cancelling dental coverage:

☐ **Self and all other family members**
I understand I must have maintained dental coverage for at least two years before I can cancel dental coverage for myself and all enrolled family members.

Terminating medical and dental coverage:

☐ **Self and all other family members**
I understand that I am forfeiting all further rights to reenroll in the PEBB program.

☐ **Other family member(s)**
Reason: ☐ **Widowed** ☐ **Divorce** Date of event_____
☐ **Other**_____
Name_____
Address_____
_____

I certify that I have read and understand the provisions above for waiving or terminating PEBB coverage.

Retiree must sign original to waive enrollment

Retiree's signature Date

When do you want the coverage to end? (mm/dd/yyyy)

SECTION 8: Authorization for Enrollment and/or Premium Deduction

I authorize the Department of Retirement Systems to deduct from my retirement allowance the amount I am required to pay for this coverage. ☐ **Yes** ☐ **No**

I certify that, to the best of my knowledge and belief, my family members and I are eligible for the coverage requested. **I understand that if I enroll in dental coverage, I must maintain dental coverage for at least two years**. This supersedes all forms I have previously submitted for Public Employees Benefits Board coverage. A premium deposit does not guarantee coverage and will be refunded if I am determined to be ineligible for coverage.

Washington State law may require disclosure of any information I submit as a public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

Retiree must sign original to authorize changes

Retiree's signature Date

Washington State Health Care Authority
Public Employees Benefits Board

Be sure to sign and date this form.

Return form to: Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684